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## **Developing trauma informed care in Northern Ireland: The justice system**

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**Adverse  
Childhood  
Experiences**

**Be the Change**



# **Developing trauma informed practice in Northern Ireland: The justice system**



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This report has been prepared for the Trauma Informed Practice Project of the Safeguarding Board for Northern Ireland.

By Queen's University, School of Social Sciences, Education & Social Work.

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# Trauma informed Care in the Justice System

## Background

In September 2018, the Safeguarding Board Northern Ireland (SBNI) commissioned a rapid evidence assessment (REA) to facilitate and support the adoption of Trauma informed practice across health, social care, justice, education, and community and voluntary systems in NI. The REA sought, primarily, to explore the evidence pertaining to organisational change processes required to implement Trauma informed care at a whole systems level, and identify some of the complexities of implementing Trauma informed processes and associated evidence of effectiveness. A systematic search of the academic literature identified more than seventy papers reporting on evaluations of organisation wide Trauma informed implementation across a range of sectors and settings. This was supplemented by a search of on-line publications, which was used to identify Trauma informed international and UK policy and practice developments and evaluations not published in academic journals.

This paper provides an overview of the principles of Trauma informed care, describing how service user experiences of adversity and/or trauma relate to the justice system and outlining international and national policy and practice developments in creating more Trauma informed justice systems. In discussing the findings from the evidence review and wider literature, consideration is given to the extent to which there is evidence that TIC implementation has led to improved outcomes for service users across systems and settings, as well as to findings and examples from the justice specific literature. Consideration is also given to the ways in which individual initiatives have incorporated change across the key implementation domains of workforce development, Trauma informed services and organisational change, as well as the associated evidence of effectiveness.

This paper is part of a suite of papers which focus on Trauma informed care in the child welfare system, the health system and the education system. It should be read in conjunction with 'Developing Trauma informed practice in Northern Ireland – Key Messages' which provides a more detailed summary of the key review findings across multiple systems and settings.

## What is Trauma informed Care?

Trauma informed care (TIC) is a whole system organisational change process which seeks to embed theoretically coherent models of practice across diverse settings and roles, including child welfare, family support, justice, mental health and education. It emerged from the findings of the seminal Adverse Childhood Experiences (ACE) study in the US (Felitti et al., 1998) with subsequent international and UK research establishing the same, strong graded relationship between the number of childhood adversities experienced (inclusive of physical, sexual and emotional abuse; neglect; and household adversity), and a wide range of negative outcomes across multiple domains over the life course (Anda et al., 2006; Anda et al., 2010; Bellis et al., 2015; Hughes et al., 2017; Van der Kolk et al., 2005). In recognising the impact of childhood adversity on child and adult outcomes, Trauma informed services strive to build trustworthy collaborative relationships with children and the important adults in their lives, as well as improve consistency and communication across linked organisations and sectors, with the aim of mitigating the impact of adversity by supporting and enhancing child and family capacity for resilience and recovery, and reducing organisational practices that may inadvertently exacerbate the detrimental effects of severe adversity and constrain engagement. Although most widely implemented in the USA, where first developed, TIC is gaining momentum as a comprehensive practice framework across the UK, Europe, Australia and New Zealand with a growing body of context-specific implementation guidance and associated evaluation generating some evidence of positive effect.

## Understanding and defining Childhood Adversity, Trauma and Resilience

### *Adverse Childhood Experiences*

While facing distressing experiences in childhood is common and normal, such as feeling stressed before exams or starting a new school, some children and young people grow up in environments or have experiences which are more emotionally distressing or difficult. These can be potentially traumatic and can have a long-lasting impact on their development, health and wellbeing. Such experiences include sexual and physical abuse and neglect within their home or community, the loss of a caregiver or sibling, and taking on adult responsibilities. These experiences can be exacerbated by wider social conditions and circumstances, such as poverty or discrimination on the basis of race, culture, gender or sexual identity. ACEs have been defined in a range of ways, depending on research foci. The following recent definition aims to expand more restrictive conventional definitions:

Adverse Childhood Experiences (ACEs) are highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence. It can be a single event, or prolonged threats to, and breaches of, the young person's safety, security, trust and bodily integrity. These experiences directly affect the young person and their environment, and require significant social, emotional, neurobiological, psychological or behavioural adaptation.

Adaptations represent children and young people's attempts to survive in their immediate environment (including family, peer group, schools and local community), finding ways of mitigating or tolerating the adversity by using the environmental, social and psychological resources available to them, establishing a sense of safety or control, making sense of the experiences they have had, the community or family that they are growing up in and the identity they are forming (Bush, 2018, p.28).

*Childhood Trauma* There is considerable overlap in the terms 'adverse childhood experiences' and 'childhood trauma' which are often used interchangeably (Bush, 2018). The Substance Misuse and Mental Health Services Administration (SAMHSA), a branch of the U.S. Department of Health and Human Services, moves beyond traditional trauma-related psychiatric diagnoses in its definition of trauma which has been adopted internationally by organisations and systems interested in transforming service delivery to better meet the needs of those who have experienced childhood adversity:

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically and emotionally harmful or life-threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual well-being (SAMHSA, 2014 p.7).

It is recognised that while children and young people who experience childhood adversity and trauma are negatively impacted by their experiences, not all will result in enduring mental health conditions or necessarily lead to a trauma-related diagnoses. This report uses the terms 'adversity and trauma' interchangeably to encompass this broader range of experiences and effects, and recognises that many of the risky and challenging behaviours displayed by children and young people in the context of adversity represent creative adjustments

## Resilience

or adaptations to their circumstances and are attempts (out of their awareness) to survive, manage and make sense of their experiences.

However, it is important to remember that the effects of adverse childhood and traumatic experiences are unique to the individual and are mediated by a range of protective factors, which help children and young people develop resilience and manage their experiences, mitigating some of the worst effects of adversity and trauma. Important protective factors for children and young people include supportive relationships with caregivers, peers and extended networks. Resilience is recognised as not just a matter of individual traits and capabilities, but rather the child's access to a supportive network, raising the important challenge of how services engage and maximise the resources available to children within their informal and formal networks:

[R]esilience is not, and should not, be viewed as an issue of individual resources and capabilities. Resilience arises through children's interactions with their social and physical ecologies, from families, through to schools and neighbourhoods. Scaffolding child development by supporting families, building healthy and happy school environments and communities, and addressing social inequalities in access to resources is crucial for enabling vulnerable children exposed to adversity to navigate their way to success. Resilience therefore depends on the structures and social policies that determine availability and access to resources (Bowes, 2018, p.89).

## What are the Core Principles of Adversity/Trauma informed Care?

With an awareness of the impact of childhood adversity and trauma on people's lives and behaviours over-time, TIC advocates developed a set of key assumptions and principles to help design responsive, holistic and effective systems of care. In bringing together a set of key principles, the effort is not to create a new set of rules, but rather to identify the core components of service culture, design and delivery that require attention (Figure 1). This includes paying attention to experience at all levels of the system, not only the service user/identified client, but also their caregivers (both families and professional caregivers), as well as practitioners, service managers and inter-agency interfaces.





Figure 1.  
SAMHSA's (2014)  
Six Principles of Trauma informed Care

The Substance Abuse and Mental Health Services Administration (SAMHSA), has identified four key assumptions underpinning Trauma informed care - what they call the four 'R's':

- (i) that all people at all levels within the system have a basic realisation about childhood trauma and adversity and how it can affect individuals, families, groups, organisations and communities
- (ii) practitioners are able to recognise the signs of trauma and adverse childhood experiences, which may be manifest by people accessing services as well as those providing services
- (iii) the system of care responds by applying the principles of adversity and Trauma informed care to all areas of functioning – from the receptionist to the chief executive – with policies, practices and language altered to appreciate the experiences of childhood trauma and adversity on service users and their families, and mitigate the risks of inadvertent re-traumatisation and secondary traumatic stress experienced by the staff providing services. TIC is inclusive of adversity and trauma-specific interventions

(such as dedicated services and interventions for substance misuse, domestic violence or post-traumatic symptoms), whether assessment, treatment or recovery supports, but also incorporates trauma principles into the organisational culture

- (iv) adversity and Trauma informed care seeks to resist re-traumatisation of service users and providers. Re-traumatisation is considered a significant concern, as people who have experienced multiple adverse life events often experience acutely exacerbated impact than those who have experienced a single trauma, resulting in decreased trust and willingness to engage with services (SAMHSA, 2014). Re-traumatisation can be present in any situation or environment that resembles an individual's original trauma experiences, literally or symbolically, which then triggers difficult feelings and reactions (SAMHSA, 2014).

While there are obvious practices that may be re-traumatising, such as restraint or isolation, the potential for re-traumatisation is thought to exist at all levels of care and is demonstrated through the use of oppressive and non-collaborative approaches to practice which violate the trust of service users and do not take account of their wishes and feelings.

### Adversity, Trauma and the Justice System

It is now well established that trauma disproportionately affects young people and adults whose lives intersect with the justice system (Miller et al., 2011) and that exposure to childhood trauma is a key risk factor for subsequent justice involvement (Kerig & Becker, 2010). For example, research involving 64,329 juvenile offenders in Florida found that they were four times more likely to report four or more ACEs (50% compared to 13%) than adults in the original ACE study (Baglivio et al., 2015). UK population-based ACE surveys have also shown that English adults exposed to 4 or more ACEs were eleven times more likely to have been incarcerated at some point in their lifetime while Welsh adults were twenty times more likely (Bellis et al., 2014; Bellis et al., 2015). Moreover, young people may respond to traumatic stress in ways which increase their chances of arrest, for example, using drugs to cope with distressing memories or running away from a family home (DeHart & Moran, 2015; Ford et al., 2006; Kerig & Becker, 2010). Similarly, adults with high ACE scores are much more likely to be high risk drinkers, use crack cocaine or heroin user, or be involved in violence (Bellis et al., 2014; Bellis et al., 2015). Accumulated evidence also suggests that trauma continues to impact the lives of individuals within the justice system. Juvenile offenders with histories of trauma have higher rates of recidivism, dual diagnosis, school dropout and suicide attempts (Cauffman et al., 2015; Haynie

et al., 2009; Wasserman & McReynolds, 2011; Wolff et al., 2015). The rate of PTSD amongst prisoners is higher than in the general population, ranging from 4% to 21% (Goff et al., 2007) and physical and sexual victimisation while incarcerated is also a significant risk (Beck et al., 2013; Beck and Johnson, 2012).

Through initial attendance at an incident through to arrest, investigation, trial, detainment and release into the community, there are innumerable interactions and a myriad of processes which have the potential to (re) traumatise those who come into contact with the justice system. While the importance of recognising and addressing the impact of trauma on victims of crime has been increasingly recognised in recent decades (Bunting et al., 2014), particularly with regard to children and other vulnerable or intimidated witnesses, applying similar principles and considerations to alleged or convicted offenders may require more of a conceptual and cultural shift. In particular, prisons and other detainment facilities, are demanding settings for Trauma informed care as their focus is on containing perpetrators, not housing 'victims' and the prison environment can be seen to be full of unavoidable triggers, such as strip searches, discipline from authority figures, and restricted movement which staff consider necessary to maintain order, manage difficult behaviours and increase safety for both themselves and other inmates (Covington, 2008; Owens et al., 2008).

As Miller and Najavits (2012) note, creating Trauma informed correctional care requires a 'balance of goals and environment'. Applying a trauma lens involves not just managing difficult behaviours and responses, but an effort to develop a deeper understanding of why some people respond the way they do and taking steps to minimise the likelihood of exacerbating existing trauma. Within juvenile justice residential settings, many difficult behaviours can be understood within the context of a young person's traumatic history. For example, young people who resist or delay showering may eventually identify an aspect of the showering process as a trauma reminder (Pickens, 2016). Equally, extreme reactions to perceived threats are often evident in group activities where young people might fear they are being seen as weak or failing and respond in an attempt to maintain psychological and physical safety (Pickens, 2016). Kubiak et al. (2017), similarly note that responses by female inmates to pat downs, strip searches or medical examinations may be perceived by staff as resistant as noncompliant, but may reflect fears about being touched emanating from previous trauma experiences.

Exposure to traumatic stressors may also impact front-line criminal justice staff. Many front-line staff have been exposed to stressors such as witnessing violence, experiencing violence and hearing details of traumatic experiences. This can lead to secondary traumatic stress among staff (Pickens, 2016). Whilst findings are mixed in relation to the precise impact of traumatic stress reactions on staff, (with studies ranging from minimal impact to upwards of 35 percent of staff endorsing core diagnostic criteria for PTSD), work-related traumatic stress symptoms are prevalent. These have been connected to impaired job performance among front-line justice-system staff (Denhof & Spinaris, 2013; Hatcher et al., 2011; Skogstad et al., 2013). The absence of adequate self-care, coupled with the impact of work stress and secondary traumatic stress can lead to high levels of job dissatisfaction, absenteeism and high staff turnover (Pickens, 2016).

### **Developments in Trauma informed Justice Systems**

Increasing recognition of the links between both trauma and criminal behaviour, and harsh punishments (i.e. seclusion) while incarcerated and continued criminal behaviour on release (Ko et al., 2017), has led many justice organisations to embrace a Trauma informed approach. Given the high prevalence of people with mental and substance use disorders involved with the justice system, SAMHSA (2017) has prioritised this population, identifying behavioural health treatment and recovery support services as critical while at the same time acknowledging that such services need to be balanced with the community priority of public safety. SAMHSA's criminal justice work is organised around a framework for intervention referred to as the Sequential Intercept Model (SIM) (SAMHSA, 2015) which identifies five key points for "intercepting" individuals with behavioural health issues, linking them to services and preventing further penetration into the criminal justice system. The SIM is a dynamic, interactive tool for developing criminal justice-human services partnerships used by communities to assess the resources, gaps, and opportunities at each intercept. It emphasises collaboration with community services, the use of diversionary programs and specialist courts, provision of a Trauma informed prison environment with access to treatment and planned release and community support (See Figure 2). Although not explicitly developed as a Trauma informed approach, there is clear applicability and overlap, and it is increasingly highlighted as a framework for applying Trauma informed principles across the continuum of justice system provision.



Many US state and county juvenile justice systems, departments of children and families, and children's advocates have also sponsored trauma initiatives across the country. Juvenile detention centres have the opportunity to provide a supportive environment giving young people access to resources to recover from trauma while receiving constant supervision (Ko et al., 2008). In some cases, this has entailed the adoption of therapeutic models such as the Sanctuary model (see Box 1), originally developed in adult in-patient psychiatric care and applied within the context of youth residential treatment and out of home care. There have also been developments with regards to specific interventions and curricula addressing trauma within correctional facilities (e.g. group-based psycho-education), although the National Resource Center on Justice-Involved Women (NRCJIW), has noted fewer efforts focused on implementing "universal precautions" or on building a more integrated, multimodal Trauma informed culture within correctional facilities (Benedict, 2014). Universal precautions are steps taken by staff, regardless of the provision of trauma specific treatment, which acknowledge the likelihood of trauma within the prison population and seek to minimise the risk of re-traumatisation. Examples include telling prisoners in advance of strip searches what will happen as a way of increasing their sense of control, not putting hands on a prisoner without telling them first, avoiding the use of restraints wherever possible, use a demeanour that carries respect, speaking calmly and using the prisoner's name (SAMHSA, 2013; Kubiak et al., 2017).

Within the UK there have also been significant interest in Trauma informed approaches within the justice system. At a policy level, Gender Specific Standards to Improve Health and Wellbeing for Women in Prison in England (Public Health England, 2018), have established the need for a Trauma informed prison environment for female prisoners as a priority. Equally 'Integrated Mental Health Service For Prisons in England'

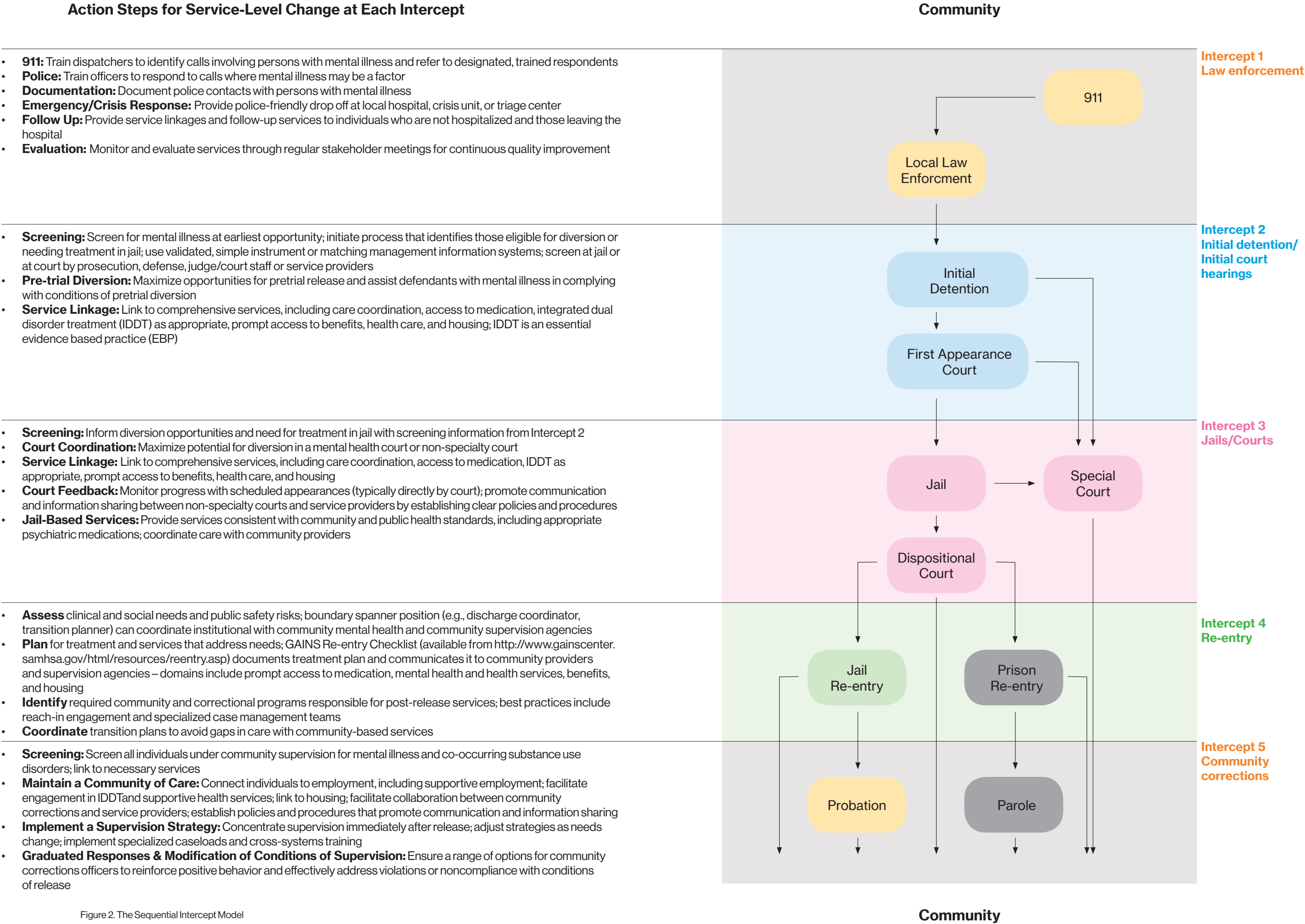
(NHS, 2018) specifies that providers should establish and run a recovery focused, Trauma informed integrated mental health service which provides psychologically-informed, evidence-based specialist support and work closely with substance misuse treatment providers and other relevant services. The 'Justice in Scotland: Vision and Priorities' (Scottish Government, 2017) strategy highlights the links between childhood adversity and contact with the criminal justice system, while a recent evidence summary (Justice Analytical Services, 2018) further develops these links, making a strong case for preventing crime by

intervening at the earliest stage possible and targeting those most at risk of experiencing adversity in childhood as well as supporting those already in the justice system.

The Welsh Government has also made a commitment to addressing the impact of ACEs, funding an ACE Support Hub dedicated to sharing expertise and raising awareness about ACEs. In terms of justice, a 2-year programme "Early Intervention and Prevention Project: Breaking the Generational Cycle of Crime", is currently being piloted in the Bridgend area of South Wales. It involves collaboration between Public Health Wales, The South Wales Police and Crime Commissioner, South Wales Police, NSPCC Cymru, Barnardos and Bridgend County Borough Council, and aims to develop a long-term approach to reducing ACEs and supporting those affected by understanding how the police respond to vulnerability. Initial research has noted high levels of police engagement with vulnerable people, highlighting how, in 2016 alone, police in South Wales made more than 60,000 public protection notifications in respect of vulnerable children and adults (Ford et al., 2017a). However, the research also found that, while police may be well-placed to identify people who are at risk of ACEs, officers and staff often had limited knowledge and understanding of ACEs or the impact of trauma. The research led to a series of series of recommendations around adopting an ACE-informed approach to neighbourhood policing which are being taken forward and have led to the development and piloting of an ACE-Informed Approach to Policing Vulnerability Training (AIAPVT) programme (Ford et al., 2017b), which is being rolled out nationally.

Other examples of justice specific Trauma informed initiatives in the UK include:

- 'In Control of Now' is a Trauma informed service currently being delivered in North East London Resettlement Consortia (Youth Justice Resource Hub, 2018). It focuses on young people who have experienced trauma, but who do not meet the thresholds for CAMHS interventions or who have refused to engage with these services, providing a trauma trained coach mentor who supports them through their journey with youth offending services, children's services or education.
- An enhanced Case Management System (ECM) based on the Trauma Recovery Model (TRM) has been tested in three youth offending teams in Wales and there are plans to replicate this in England and other parts of Wales (CordisBright, 2017).



## Box 1. The Sanctuary Model

The Sanctuary Model represents a theory-based, Trauma informed, trauma-responsive, evidence-supported, whole culture approach that has a clear and structured methodology for creating or changing an organisational culture. The model is informed by four knowledge areas: the psychobiology of trauma, actively creating nonviolent environments, social learning principles, and understanding complex system change.

Core components: The Sanctuary model combines trauma theories, an enhanced therapeutic community philosophy and strategies to address post-traumatic symptoms, unhelpful coping strategies and disruptions to children's development.

**1. Trauma theories** – A Trauma informed community recognises our inherent vulnerability to the adverse effects of trauma and organises system-wide interventions aimed at mitigating these (Bloom, 2005). Sanctuary recognises that trauma can arise from discrete events and the impact of cumulative and less tangible experiences such as poverty. A Trauma informed culture can make sense of children's behaviour and, by using trauma-specific approaches, can help children to recover or heal.

**2. Enhanced therapeutic community philosophy** – Like the individuals they aim to help, organisations and the staff within them can misapply survival skills and produce dysfunctional (defensive) ways of behaving. This can result in environments that exacerbate children's problems. Sanctuary therefore addresses the need for systemic level change (the so-called parallel process). It has adopted a set of values (seven commitments), based on UK therapeutic community standards, to help individuals and organisations avoid trauma-reactive behaviours and to develop the organisational context necessary to provide a therapeutic environment for children.

**3. The Sanctuary toolkit** – This refers to a portfolio of skills designed to help teams and individual staff members work more effectively, particularly in difficult situations. They include community meetings, team meetings, safety plans, psycho-educational groups and SELF – a framework that equips staff and children with a non-technical language that provides a more helpful perspective on the recovery process.

Source: <http://sanctuaryweb.com/Home.aspx>

## How Can Trauma informed Care Benefit Those in Contact with the Justice System?

Out of the seventy plus academic papers evaluating organisation wide Trauma informed implementation, more than half focused on child welfare and many did not specifically evaluate child or family outcomes. Where data was available, with a few notable exceptions, the generalisability of study findings was often limited by the use of non-randomised designs, lack of a control or comparison group, small sample sizes and/or lack of standardised, validated measurement tools. In spite of these limitations, the review highlighted a growing body of evidence pointing to the positive impact TIC can have on service users across various settings through improved child mental health outcomes, improved patient-provider rapport, reductions in the use of seclusion and restraint, fewer substantiated child maltreatment reports, reduced caregiver stress, decreases in school disciplinary offences and suspensions, and reduced youth aggression (see 'Key Messages' report).

The review identified six empirical peer-reviewed studies which evaluated TIC interventions within the justice sector, four of which related to juvenile justice/secure residential settings (Elwyn et al., 2015; Elwyn et al., 2017; Marrow et al., 2012; Caldwell et al., 2014), and two which evaluated Trauma informed multi-agency service provision, of which justice was part (Damian et al., 2017; Suarez et al., 2014). The four juvenile justice/secure residential evaluations highlighted associations between Trauma informed care implementation and reduced youth misconduct and reduced assaults on youth by peers (Elwyn et al., 2015), reduced staff and youth grievances (Elwyn et al., 2015), improved youth mental health and greater levels of optimism and hope (Marrow et al., 2012), fewer threats toward staff (Marrow et al., 2012) and fewer incidents of restraint or seclusion (Elwyn et al., 2015; Caldwell et al., 2014; Marrow et al., 2012).

The on-line search of policy and practice literature identified additional international and UK Trauma informed justice initiatives, examples of which are discussed in the previous section. While many of these have yet to be evaluated, four papers included evaluation data (Cordis Bright, 2017, Ford et al., 2017b, Benedict, 2014; Heilbrun et al., 2012), although, as with the academic literature, this was often based on small numbers, qualitative methodologies, and/or research designs lacking a control group. Bearing in mind these limitations, some initial data and process evaluations did, however, point to the potential contribution of Trauma informed approaches to positive outcomes for those in contact with the justice system. For example, a case file review and qualitative interviews with stakeholders involved a new Enhanced Case Management (ECM) in three youth offending



teams in Wales, suggested that the young people who participated achieved improvements in their quality of life and quality of relationships with agencies, as well as reductions in reoffending and reoffending severity (Cordis Bright, 2017). Likewise, the implementation of TIC in adult women's prisons in the USA was linked to reductions in staff-inmate assaults, inmate-inmate assaults and other disciplinary incidents (Benedict, 2014).

Although not initially developed as a Trauma informed initiative per se, the Sequential Intercept model also has its own developing evidence base which supports the potential effectiveness of specialised interventions across multiple dimensions of the justice system. A systematic research review (Heilbrun et al., 2012) has shown that, at Intercept 1, developments to provide police officers with a greater range of approaches to interacting with individuals with behavioural health disorders (e.g. crisis intervention teams), were effective in diverting mentally ill individuals in crisis from arrest and linking them with appropriate services. There was also evidence to indicate less application of force during the initial encounter with police. However, the review also highlighted a lack of evidence to suggest that such specialised responding, by itself, was associated with lower rates of arrest when individuals were followed over periods of 12 months and compared to other individuals who had not been diverted. Evidence for effectiveness (Heilbrun et al., 2012) at other intercept levels included:

- Intercept 2 – Efforts to divert individuals with mental illness from standard prosecution post-arrest resulted in more time spent in the community and more frequent and intensive participation in various kinds of treatment activity. Research also suggested that diverted individuals were re-arrested less frequently than non-diverted individuals, although the need for caution in interpreting these was highlighted.
- Intercept 3 – Research on the use of specialty courts, such as drug courts, mental health courts, and community courts, produced mixed evidence regarding relapse rates for drug courts but more consistent evidence that specialty courts reduced the incidence of subsequent arrest and incarceration.
- Intercept 4 – Enhanced treatment provided within the context of assertive community treatment programs or intensive case management programmes, were associated with better criminal justice outcomes (e.g. booking, conviction, mean jail time), better improvement in substance abuse problems, and greater improvement in global functioning and economic self-sufficiency, relative to those receiving treatment as usual.

- Intercept 5 – Specialty probation/parole services were highlighted as holding considerable promise for improving clinical and criminal outcomes for probationers and parolees with a mental illness, although outcomes were mediated by service user perceptions of psychiatric medication and broader treatment motivation. Specialty officers were less likely to respond to non-compliance with punitive strategies than traditional officers.

### **How has Trauma informed care been implemented?**

Given that TIC requires change at multiple levels of an organisation, advocates have developed guidance for implementing a Trauma informed approach. Building on Harris and Fallot's (2001) preliminary work, SAMHSA's (2014) identified ten implementation domains and proposed a series of questions to consider in each domain (see Table 1). Similarly, Branson et al. (2017) and Hanson & Lang (2016) have identified multiple implementation domains as the basis of Trauma informed justice and child welfare systems. These centred around the broad implementation categories of clinical services, agency context and system level changes (Branson et al., 2017) and workforce development, Trauma informed services and organisational changes (Hanson and Lang, 2016). Education and health-based frameworks (Dorado et al., 2016; Shambin et al., 2016; Raja et al., 2015) have incorporated similar features and components, emphasising tiered approaches to TIC which support trauma-sensitive awareness and practice with all patients and students, and more targeted approaches for those displaying some level of trauma-related need, moving towards screening for childhood adversity and trauma and referral to trauma-specific services for those with identified trauma symptomology or other specific issues (such as having witnessed domestic violence or experienced sexual violence). While the specific components of TIC are context-dependent, and there are minor variances in articulation and structuring between the different frameworks, the rapid evidence review identified considerable commonality with the broad implementation domains of workforce development, trauma-focused services and organisational change (Hanson & Lang, 2016) reflected across all settings. Key implementation components within each domain and associated evidence of effectiveness across systems, as well as specifically in relation to the justice system, are discussed below.



**Workforce  
Development**

**Training** - Training was, by far, the most commonly evaluated element of TIC implementation across initiatives and settings. Although limited by the preponderance of pre and post-test designs with short follow-up periods and a reliance on self-report measures, studies invariably demonstrated increases in staff knowledge, awareness and confidence in Trauma informed principles and practice. The justice specific academic literature focused primarily on juvenile justice settings with training delivered on specific therapeutic models such as the Sanctuary model (Elwyn et al., 2015; Elwyn et al., 2017), Six Core Strategies (Caldwell et al., 2014) and Trauma Affect Regulation: Guide for Education and Therapy (TARGET) [Marrow, et al., 2012]. For example, TARGET training, entailed one-day psycho-educational general trauma training designed to provide information on childhood trauma and its prevalence in juvenile justice involved youth; the relationship between traumatic events/traumatic reactions and dysregulated emotions and behaviours in youth; potentially traumatising practices that occur in juvenile justice facilities; an overview of positive coping strategies youth could use; and planning for and design of trauma-sensitive environments. This was followed by two-day training on Trauma Affect Regulation: Guide for Education and Therapy (TARGET) principles, again delivered to all staff, and designed to teach a seven-step sequence of skills to assist young people and adults in processing and managing trauma-related reactions to current stressful experiences.

In terms of the policy/practice literature, the ‘Enhanced Case Management’ pilot in Welsh Youth Offending Teams, highlighted a focus on developing staff understanding of child development, parent-child attachment, how trauma experienced by a child can impact on a child’s development, as well as the theory underpinning the Trauma Recovery Model and how it could be used by practitioners (Cordis Bright, 2017). Similarly, an ‘ACE-Informed Approach to Policing Vulnerability’ training programme has been developed and piloted in South Wales to help equip police with a better understanding of the impact of ACEs and trauma on the behaviour of vulnerable people and the basic skills for responding to emotional trauma behaviour. The programme was delivered in two sessions with session one involving all operational staff (i.e. Response and Neighbourhood Policing Teams) and Session two targeting Neighbourhood Policing Teams only (see Box 2). As with the international peer-reviewed literature, pre and post training evaluation showed increases in knowledge of, and confidence in, responding to vulnerability (Ford et al., 2017b). Police officers who took part in interviews also reported positive changes in their judgements and a more measured response towards individuals who they previously had typically viewed as problematic and/or confrontational.

**Box 2.  
ACE-Informed  
Approach  
to Policing  
Vulnerability  
Training Content**

**Session 1**

- Working with vulnerability
- Understanding what toxic stress is and its impact on well-being
- The impact of trauma on brain development, behaviour and response to threat
- Outlining what ACEs are and the research evidence of associations with poor health outcomes
- Applying Trauma informed practice to policing
- Staff well-being and managing secondary trauma

**Session 2**

- Understanding thresholds for social-services and early help
- Advantages and challenges of multi-agency working
- Stages of Change
- Motivational interviewing techniques
- The importance of protective factors and how to promote resilience

**On-going staff support** – Various initiatives stressed the importance of on-going staff support as crucial to maximising the impact of initial training and embedding TIC in practice. Across settings, this included the use of learning collaboratives, coaching, mentoring and monitoring of fidelity to the Trauma informed model through supervision, on-going consultation and coaching from model developments/trainers or other experts and continuous staff training, booster sessions and/or recertification processes. Strategies to address this in the justice system included: on-going supervision, consultation or coaching during the implementation phase (Marrow, et al., 2012), the provision of clinical supervision (Cordis Bright, 2017) and the development of practice guidance (Cordis Bright, 2017). In the case of multi-agency training provided to law enforcement, Social Services, Health and Education professionals, in addition to a nine-month training programme, participants also received a series of monthly technical assistance, coaching and feedback sessions from national trauma experts on how to utilise Trauma informed practices at their agencies.

**Self-care** - Self-care also featured as a component of TIC implementation in a number of initiatives, although it was not as widespread as the practice related supports discussed above. In some cases, this entailed the creation of specific teams to provide peer support to colleagues but more often took the form of emphasising self-care strategies in TIC training. For example, implementation of Six Core Strategies in residential/secure settings (Caldwell et al., 2014) involved establishing a team of staff, called the ASAP Team, who provided peer support and immediate support for staff who experienced trauma. Additionally, implementation of the Sanctuary Model in a juvenile justice facility in Pennsylvania over a three-year period led to reductions in staff grievances, improved relationships within the staff team and between staff and residents, as well as a reduction in assaults on staff and reduced youth misconduct (Elwyn et al., 2015). Further investigation of the implementation process using qualitative interviews and focus groups with staff also pointed to positive changes with regard to safety, staff attitudes and relationships, unit atmosphere, accountability, and relationships with residents (Elwyn et al., 2017).

## Trauma Focused Services

**Screening and Assessment** – Although none of the review papers focused on screening within justice settings, Branson et al.'s (2017) systematic review highlighted universal screening/assessment of youth for trauma-related impairment as a core component in developing Trauma informed juvenile justice systems. Similarly, initial research emerging from the Early Intervention and Prevention Project in South Wales has recommended that consideration be given to using ACE-informed routine enquiry in neighbourhood policing (Ford et al., 2017a). Review findings involving implementation of trauma screening within the child welfare and health systems (Lang et al., 2017; Lotzin et al., 2017; Miller et al., 2017; Decker et al., 2017; McGee et al., 2015), showed that screening was generally perceived favourably by professionals, leading to increases in identification of adversity/trauma exposure amongst service users and increases in service user perceptions of support and confidence in service providers.

However, various challenges related to routine inquiry and assessment were also noted. These commonly included systemic issues such as the size and scope of the system, the number of staff, competing demands, staff turnover etc., as well as specific issues around buy-in, local availability of evidence-based treatment/services and problems with information technology systems (Akin et al., 2017; Lang et al., 2017). In one UK study, three services piloting routine inquiry through the use of a standalone implementation pack (Quigg et al., 2018) eventually decided not to continue the initiative post pilot. Although reasons for this were multi-faceted, it was noted that the implementation pack,

and potentially the academic literature, did not provide sufficient information on how to use the information gathered from routine enquiry on ACEs to inform service provision and the support offered to clients, particularly within the types of services included in the pilot. Overall, it was felt that clearer theoretical foundations, more developed guidance on responding to disclosures, particularly from children, and broader approaches beyond the provision of a standalone implementation pack, were required to ensure services and practitioners were ACE-informed.

**Evidence-based treatment, adversity and trauma-focused services** – Various child welfare, residential/secure and schools-based initiatives incorporated strategies to build treatment/intervention capacity in-house or increase access to evidence-based treatments via referral to other agencies. In residential/secure settings, the majority of implementation initiatives adopted specific Trauma informed models of practice such as Six Core Strategies, Risking Connection, Collaborative Problem Solving (CPS), the Fairy Tale Model, ARC and Sanctuary (Bryson et al., 2017; Bailey et al., 2018; Elwyn et al., 2015; Elwyn et al., 2017; Caldwell et al., 2014; Marrow et al., 2012). Bryson et al.'s (2017) systematic review indicated that implementation of these therapeutic models led to a significant reduction in the use of restraint and/or seclusion across a range of studies, with a smaller number demonstrating improved mental health outcomes for residents.

In addition to specific therapeutic models/treatment, a range of other Trauma informed support services were provided as part of the implementation process. In one residential/secure facility, these included the use of sensory tools such as pet therapy, visits to animal shelter, music therapy, cooking and swimming (Caldwell et al., 2014). Similarly, in addition to evidence-based treatments, a collaborative project involving mental health, education, juvenile justice, and child welfare sectors provided community-based peer support for young people and caregivers and structured group activities (Suarez et al., 2014).

**Leadership buy-in and strategic planning** - Many of the initiatives reported were part of broader, organisation wide Trauma informed implementation strategies aimed at changing organisational culture and practices. Key elements of implementation across settings focused on establishing leadership buy-in, often through providing initial training to agency directors and senior management, establishing implementation teams, developing strategic implementation plans and structures, and assessing organisation readiness. Leadership was less commonly emphasised in residential/secure care initiatives, although the adoption of



organisation wide Trauma informed models, by their nature, involved leadership buy-in. The Sanctuary Model, in particular, was emphasised as a model which targeted key leaders in initial training phases, who then returned to their agency to form a Core Team of representatives across all levels and departments who would act as the primary change agents going forward (Elwyn et al., 2017; Elwyn et al., 2015; Middleton et al., 2015).

**Developing policy, procedures and data systems** - A number of papers drew attention to the specific changes made to policies, processes and data systems as part of the implementation process (Lang et al., 2016; Hummer et al., 2010; Caldwell et al., 2014; Akin et al., 2017). In residential/secure facilities, policy and procedural changes took the form of integrating TIC principles into the residents' handbook and treatment plans; and posting signs detailing the TIC principles around the facility (Elwyn et al., 2017); developing policies to identify child and youth preferences regarding de-escalation (Hummer et al., 2010); and amending procedures to include systematic debriefings following staff use of seclusion and restraint, (Hummer et al., 2010; Caldwell, 2014). A qualitative case study evaluation of the TIC implementation process in out-of-home care facilities in three states (Akin et al., 2017), further highlighted how embedding adversity and Trauma informed screening and assessment in practice required the development of electronic systems to collect and share data as well as policy amendments to facilitate information sharing between agencies. This presented various challenges which, although eventually overcome, caused significant revision of initial implementation plans.

**Changes to the Physical Environment** - Bryson et al.'s (2017) systematic review of in-patient and youth residential treatment noted that, in the therapeutic community model, the environment and culture of the organisation are seen as therapeutic tools in themselves. Thus, organisations were encouraged to make changes to the physical environment of the unit to make the treatment/residential space feel safe and welcoming for both patients/service users (both children and adults) and staff. For example, changes made to physical environment in a paediatric psychiatric hospital included repainting walls with warm colours, placement of decorative throws, rugs and plants, and rearrangement of furniture to facilitate increased patient-patient and patient-staff interaction (Borckardt et al., 2011). TIC teams (including staff at different levels of seniority/role and service users) were also established for each unit and tasked with reviewing and modifying unit rules and policies to be less restrictive to patients/service users or eliminating unit rules that were too restrictive. Interestingly, a multiple-baseline evaluation with random implementation of intervention components, found

that these environmental changes were uniquely associated with a significant reduction in the rates of seclusion and restraint (Borckardt et al., 2011), suggesting that fairly minor and inexpensive changes can make a significant difference.

**Engaging with Youth and Families** - Engagement with children, young people, parents/ caregivers and extended networks was also an important element of the implementation process in a number of initiatives. Service user involvement took a variety of forms across systems and settings: including patients/young people and/or caregivers in training initiatives; parent/caregiver involvement and systematic debriefing of young person following the use of seclusion or restraint; getting service user perspectives, employing a peer specialist to act as a patient advocate; engaging family members/supportive adults and patients/young people in case/treatment planning; conducting focus groups with service users as part of a community Trauma informed site assessment; and including service user representatives (young people and families/caregivers) in TIC leadership teams. Caldwell et al. (2014), in particular, highlighted the effective and meaningful use of service user involvement to bring about organisational change in residential/secure settings. In this initiative, young people were invited to share their experiences of restraint with staff, highlighting how restraint resulted in a loss of self-respect and dignity, and in feeling less safe when witnessing peers being restrained. It was reported that this initiative, together with the involvement of family members and significant others, was central to the project's success in reducing seclusion and restraint by 67-100% across sites.

### **What might adversity and Trauma informed care look like in Northern Ireland?**

The complexity and range of TIC initiatives makes comprehensive evaluation a difficult task and, generally, the literature was not able to isolate which implementation elements contributed to implementation success. However, various systematic reviews, (Purtle et al., 2017; Bryson et al., 2017), point to Trauma informed organisational interventions which incorporate multiple components as having the most meaningful impact upon service user and caregiver outcomes. Initiatives identified in the rapid evidence review commonly targeted the implementation domains of workforce development, the provision of trauma-focused services and organisational change. Consistency was evident with regard to implementation components within these domains, although the extent to which they were incorporated within individual initiatives varied. Table 2 summarises these cross-system implementation components with a view to offering a framework for developing and benchmarking Trauma informed initiatives within the NI context.

WORKFORCE DEVELOPMENT	
Training	<ul style="list-style-type: none"><li>• Basic and/or advanced training dependent upon staff role</li><li>• ‘Train the Trainer’ as a method of cascade training</li><li>• Use of group forums (such as Learning Collaboratives) to embed models of reflective practice, and consolidate learning and practice change</li><li>• Team access to on-going Trauma informed consultation and supervision</li><li>• Evaluation processes are embedded within TIC training initiatives</li></ul>
Staff Safety and Well-being	<ul style="list-style-type: none"><li>• Relevant staff training to understand vicarious traumatisation and promote self-care strategies</li><li>• Access to staff wellbeing support services</li><li>• Availability of regular staff/team debriefing, learning and support forums, in particular after significant incidents</li></ul>
TRAUMA-FOCUSED SERVICES	
Screening and Assessment	<ul style="list-style-type: none"><li>• Where appropriate, develop appropriate methods of routine inquiry about adverse childhood experiences and trauma, including availability of protective factors</li><li>• Staff receive initial training and ongoing support in utilising trauma screening tools or assessment models</li><li>• Frontline practitioners are clear why and how routine screening information will be used and how to discuss ongoing need with service users</li><li>• Availability of local trauma and adversity-specific services, and referral processes are considered</li><li>• Incorporation of TIC screening/assessment results into existing data systems or assessment processes e.g. systematic recording of current or past adverse experiences of child/young person and key resources and relationships</li><li>• TIC screening/assessment is routinely discussed at team meetings and senior management fora, identifying service challenges and developments</li></ul>

Table 2. Key Components of CROSS SYSTEM Trauma informed Implementation

Evidence-Based Treatment/ Trauma-focused Services	<ul style="list-style-type: none"><li>• Dissemination of selected evidence-based treatment models in residential settings</li><li>• Increasing availability of trauma specific treatment services to meet identified need</li><li>• Developing trauma-focused support services (e.g. training/mentoring services for young people and parents/ caregivers, group/classroom-based psychoeducation, Trauma informed intake and family assessments or embedding TIC expert/clinician within agencies)</li></ul>
ORGANISATIONAL CHANGE	
Leadership buy-in & Strategic Planning	<ul style="list-style-type: none"><li>• Deliver leadership TIC training</li><li>• Development of implementation plans</li><li>• Creation of multidisciplinary implementation teams, including identification of TIC champions</li><li>• Identification of specific goals/targets depending on agency setting/context/priorities</li><li>• Assess and strengthen organisational preparedness</li><li>• Review TIC fit with policies and procedures and revise accordingly</li><li>• Identify key areas for change where practices risk child and family/care-giver re-traumatisation e.g. where/when restraint happens, removal of children</li><li>• Review and revise data systems to facilitate the storage, retrieval and sharing of pertinent childhood adversity/trauma information</li><li>• Ensure necessary resources are available to facilitate new initiatives e.g. workforce development etc.</li></ul>
Collaboration	<ul style="list-style-type: none"><li>• Identify clear intra and inter-agency/sector referral pathways and data sharing where appropriate</li><li>• Establish shared understanding of adversity and TIC across systems, staff levels and disciplines</li><li>• Establish collaborative multi-disciplinary case conferences/ care team meetings, including and prioritising service user engagement (both child and parent/family/caregiver)</li><li>• Establish partnerships with community and voluntary sector organisations</li></ul>



**Physical Environment**

- Establish a shared multidisciplinary staff/service user/caregiver team to undertake a review of the physical space and relevant residential unit policies/procedures
- Use staff/service user/caregiver ideas to create a welcoming physical environment where peer and patient/service user/caregiver-staff interaction is encouraged
- Publicly post mission statements which highlight awareness of service user adversity and trauma, and commitment to TIC principles
- Create ‘safe spaces’ where services users/care-givers and frontline staff can go to calm down and allow tensions to be de-escalated

**Service User Involvement and Peer Support**

- Establish a commitment to decreasing agency-young person/caregiver power differentials and maximising service user involvement (children/young people and their parents/caregivers) in all agency policies and procedures Include young people and parents/families/caregivers in TIC training, either directly or via integrating their perspectives in training materials
- Involvement of service user perspectives (both children/young people and their families/caregivers) in Trauma informed organisational assessment, leadership/implementation teams, service development initiatives and evaluation processes
- Establish routine service user (young person and family/caregiver) feedback mechanisms
- Create opportunities for young people and their families/caregivers to meet with others experiencing similar circumstances to promote shared learning and mutual support

**Monitoring and Review**

- Establish clear goals with regard to practice/outcome changes desired
- Utilise or adapt current systems to audit, monitor progress and evaluate TIC implementation/service development priorities to address practice challenges and capture critical practice learning
- Regular communication with staff and service users about TIC implementation progress and on-going learning
- Monitor model/implementation fidelity (dependent upon TIC initiative)

Such developments need to acknowledge and build on existing work and recent NI initiatives, which, while not necessarily emanating from TIC discourses, have much in common with TIC principles. While TIC offers an opportunity to bring purposeful theoretical and practice coherence across service settings, with enhanced outcomes for children and their parents/caregivers, it should be recognised that effective TIC implementation is not without challenges, which require close consideration in the development phase of any proposed implementation strategy. Leadership commitment is required from the outset to support organisational level culture and systems change, embedding meaningful service user and practitioner involvement in Trauma informed service design and development, and establishing routine research and evaluation processes to drive change. Reviewing system and organisational level policy and procedures to ensure ‘fit’ with adversity and Trauma informed principles is also required to provide the necessary framework to support changes in service delivery.

Evidence from the rapid evidence review highlighted that effective ACE routine screening/enquiry implementation requires the support of fit-for-purpose IT and data-sharing systems, and critical buy-in of all staff through dissemination of a sound theoretical and empirical rationale (Quigg et al., 2018). Assessment of the availability of evidenced-based trauma/adversity treatments/services and Trauma informed support services is another key consideration. Lack of support services to meet identified need can act as a significant barrier to staff engagement. Successful initiatives, particularly at the state-wide level, all made significant effort to build capacity amongst community mental health and other service providers.

Given that a lack of understanding of the experience and impact of childhood trauma (Sweeney et al., 2018), and reluctance to ask about early adversity (Huntington et al., 2005; Quigg et al., 2018; Read et al., 2017; Xiao et al., 2016) are identified barriers to TIC, it is essential to equip the NI workforce with effective, professionally relevant and comprehensive childhood adversity and trauma-awareness training. The evidence suggests that while one-off training sessions can deliver some gains, staff will be enabled to maintain interest and more effectively embed TIC principles in their everyday practice if offered repeated and ongoing supportive reflective practice learning opportunities. TIC represents a significant shift in thinking and practice for many agency contexts and, to be effective, training needs to take

Table 2. Key Components of CROSS SYSTEM Trauma informed Implementation cont.

account of the ‘needs and norms’ of specific professional groups. Professional reluctance to shift from dominant biomedical causal models of mental health or normative use of control-orientated coercive practices (such as restraint and seclusion) in group care and justice settings (Sweeney et al., 2018) need to be recognised and addressed in training content. Involving staff and service users in the design and delivery of training content is one of a number of ways this might be achieved.

Additionally, more generic system pressures such as high caseloads, workload pressures, lack of quality supervision, high staff turnover and underfunding all require consideration in TIC implementation planning. These pressures, if unaddressed, will inevitably mitigate against the sort of relational practice proposed by TIC frameworks and the amount of time staff have to commit to new initiatives (Atwool, 2018; Sweeney et al., 2018). Indeed, time itself is arguably the most important consideration of all. Funders, commissioners and senior managers need to be aware that the kind of whole system change envisaged by TIC will take some initial investment of time and energy, and that “allocating process time for the slow and organic changes that must take place to accommodate the new way of practicing should be factored into TIC implementation plans” (Bryson et al., 2017: p12). However, with the right resource and a commitment to thoughtful planning and ongoing review, this rapid evidence review demonstrates that adversity and Trauma informed systems of care offer potentially valuable gains not only for children and young people, their extended networks and communities, but also for practitioners, service managers and commissioners, and indeed, society as a whole.

## RESOURCES

### **SAMHSA** - <https://www.samhsa.gov/>

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioural health of the nation. SAMHSA’s mission is to reduce the impact of substance abuse and mental illness on America’s communities. It offers a variety of free resources and guidelines:

- Understanding Child Trauma - <https://www.samhsa.gov/child-trauma/understanding-child-trauma>
- SAMHSA’s Concept of Trauma and Guidance for a Trauma informed Approach - <https://store.samhsa.gov/shin/content//SMA14-4884/SMA14-4884.pdf>
- Alternatives to Seclusion and Restraint - <https://www.samhsa.gov/trauma-violence/seclusion>
- Trauma informed Care in Behavioural Health Services - [https://store.samhsa.gov/shin/content//SMA14-4816/SMA14-4816\\_LitReview.pdf](https://store.samhsa.gov/shin/content//SMA14-4816/SMA14-4816_LitReview.pdf)  
<https://store.samhsa.gov/shin/content//SMA14-4816/SMA14-4816.pdf>

### **National Child Traumatic Stress Network (NCTSN)** - <https://www.nctsn.org/>

NCTSN is a group of 70 treatment and research centres from across the United States that has been instrumental in implementing Trauma informed child welfare initiatives not just in the USA, but internationally. Free access to range of online training resources and guidance can be obtained through registration with the ‘NCTSN Learning Center for Child and Adolescent Trauma’. Resources include:

- The 12 Core Concepts for Understanding Traumatic Stress Responses in Children and Families
- Child Welfare Trauma Training Toolkit
- Resource Parent Curriculum (RPC)
- The Child Trauma Toolkit for Educators
- Working with Parents Involved in the Child Welfare System



## Chadwick Trauma informed System Project- <https://ctisp.org/>

The Chadwick Trauma informed Systems Dissemination and Implementation Project (CTISP-DI), and its predecessor the Chadwick Trauma informed Systems Project (CTISP), promote creating Trauma informed child welfare systems. It provides free access to training and implementation guidance:

- Free Downloadable: CTISP's Trauma informed Child Welfare Practice Toolkit - [https://ctisp.org/Trauma informed-child-welfare-practice-toolkit/](https://ctisp.org/Trauma-informed-child-welfare-practice-toolkit/)
- CTISP-DI Trauma informed Child Welfare Resources and Webinars - [https://ctisp.org/ctisp-Trauma informed-child-welfare-resources-and-webinars/](https://ctisp.org/ctisp-Trauma-informed-child-welfare-resources-and-webinars/)

## The Health Care Tool Box: <https://www.healthcaretoolbox.org/>

Provides information on Trauma informed health care including access to research summaries, education materials and other tools and resources

## NHS Health Scotland - Adverse Childhood Experiences (ACEs) - <http://www.healthscotland.scot/population-groups/children/adverse-childhood-experiences-aces/overview-of-aces>

Provides access to an overview of ACES in Scotland and Scottish national Strategies:

- Tackling the attainment gap by preventing and responding to Adverse Childhood Experiences – <http://www.healthscotland.scot/media/1517/tackling-the-attainment-gap-by-preventing-and-responding-to-adverse-childhood-experiences.pdf>
- 'Polishing the Diamonds' - Addressing Adverse Childhood Experiences in Scotland - [https://www.scotphn.net/wp-content/uploads/2016/05/2016\\_05\\_26-ACE-Report-Final2.pdf](https://www.scotphn.net/wp-content/uploads/2016/05/2016_05_26-ACE-Report-Final2.pdf)
- Routine Enquiry Seminar Report - <http://www.healthscotland.scot/media/1556/routine-enquiry-seminar-report.pdf>

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